

**TEXAS TECH UNIVERSITY
CERTIFICATION OF PHYSICIAN OR PRACTITIONER**

1. Employee's Name: (Please Print) _____
2. Patient's Name: (If other than employee) _____
3. A "**Serious Health Condition**" under the Family and Medical Leave Act should meet one of the following conditions. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

Hospital Care

- Inpatient care (i.e., an overnight stay) in the hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

Absence plus Treatment

- A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:
1. **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
 2. **Treatment** by a health care provider on **at least one occasion**, which results in a **regimen of continuing treatment** under supervision of the health care provider.

Pregnancy

- Any period of incapacity due to **pregnancy** or for **prenatal care**.

Chronic Conditions Requiring Treatment

- A chronic condition that:**
1. Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
 2. Continues over an extended period of time (including recurring episodes of single underlying condition); and
 3. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

Permanent/Long-term Conditions Requiring Supervision

- A period of **incapacity** that is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stage of a disease.

Multiple Treatments (Non-chronic Conditions)

- Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, or for a condition that **would likely result in a period of incapacity for more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

4. Describe the **medical facts** that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5a. State the approximate **date** the condition commenced, and the probable **duration** of the condition (as well as the probable duration of the patient's present **incapacity**, if different). Incapacity for purposes of FMLA is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)? Yes No If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition 4 above) or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency or **episodes** of incapacity.

6a. If additional **treatments** will be required for the condition, provide an estimate of the number of such treatments:

If the patient will be absent from work or other daily activities because of treatment for an **intermittent or part-time basis**, also provide an estimate of the number of and interval between such treatments, actual or estimated dates of treatment, if known, and period required from recovery, if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment).

7a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the **employee unable to perform work** of any kind? Yes No

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)?
 Yes No If yes, please list the essential functions the employee is unable to perform:

c. If neither a nor b applies, is it necessary for the employee to be **absent from work for treatment**? Yes No

8a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety or for transportation? Yes No

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? Yes No

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

(Signature of Health Care Provider)

(Type of Practice)

(Street Address or P.O. Box)

(Area Code & Telephone Number)

(City, State, Zip)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

(Employee Signature)

(Date)